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| **Case Number:** | CM13-0018969 | | |
| **Date Assigned:** | 03/12/2014 | **Date of Injury:** | 03/23/2008 |
| **Decision Date:** | 05/21/2014 | **UR Denial Date:** | 08/06/2013 |
| **Priority:** | Standard | **Application Received:** | 09/03/2013 |

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Internal Medicine, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

## CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 43 year old female who was injured on 3/23/08 while steering and pushing a gurney. She is diagnosed with depressive disorder, panic disorder with agoraphobia, L5-S1 radiculopathy, and post-laminectomy pain syndrome. Prior treatment history has included pain management and at least three lumbar epidural steroid injections. The patient underwent microdiscectomy in September 2008, a back stimulator implant in February 2012, and another surgery in 2013 with spinal cord stimulation. As of 1/13/14, her medications include Alprazolam, Fluoxetine, Zolpidem, Ibuprofen, Gabapentin, Percocet, laxatives, and senna compounds. As of 1/3/14, her medications included Xanax 2mg, three times a day; and Zolpidem. As of 11/19/13, her medications included Prozac, Xanax, Ambien, Percocet, Gabapentin, and Prilosec. As of 11/14/13, her medications included Percocet, Neurontin, Xanax, Ambien, and Ibuprofen. A urine drug screen collected on 12/12/13 was consistent with prescription therapy. A urine drug screen dated 10/22/13 was positive for metabolites of Fluoxetine, benzodiazepines, Oxycodone, and Ambien. A gastroenterology and qualified medical examiner report dated 1/13/14 documented the patient to have complaints of frequent generalized abdominal pain, which occurs 2-3 times per week, along with significant constipation. The pain is rated as high as 9/10. She reports that her symptoms started gradually many years ago when she was injured at her job site, as she was also given different medications including narcotics and NSAID medications. She has also lost a significant amount of weight subsequent to work injury. She reports that during the night, she occasionally has been awakened by feeling pressure over the epigastric area. She denied any dysphagia or odynophagia at that time. She took some nonsteroidal anti-inflammatory agents beginning in 2013 for a few months and now she takes them occasionally. The patient complained of headaches, neck pain, increased saliva, voice changes in the morning, and cough during the night. She complained of pain over the lower back and hips. Psychological exam

revealed severe anxiety, depression, and sleep problems, and has been followed by a psychological consultant. She also reported that she has most symptoms in the GI tract when she is under anxiety, stress, and worry. Her back examination was non-significant, except for tenderness over the lower back area. Her neurological examination was non-significant. The patient was recommended to begin drinking eight glasses of water on a daily basis, and to also increase physical activity by working on a daily basis. A follow-up psychiatric consultation on 1/7/14 indicated that the patient's current psychiatric complaints consisted of anxiety, tension, and irritability, which are reduced. Her depression is reduced, as are occasional crying episodes. She states that her insomnia is constant due to pain and worry, and her memory and concentration are impaired. She suffers from panic attacks and agoraphobia. She has no energy level, no sociability, and her sexual activity is low due to pain. Her mental status examination revealed that she walks with a cane slowly and stiffly. The patient was diagnosed with depressive disorder, not otherwise specified; and panic disorder with agoraphobia. The patient was recommended Prozac 40mg tablets, 1 every morning after eating; 60 Ambien 10mg, 2 at bedtime as needed; and 120 Xanax 2mg, 1 twice a day as needed. An agreed medical examination dated 1/3/14 states that the patient continued with pain management, psychiatric treatment, orthopedic follow-up, and tapering her medication. She eventually had her dorsal stimulator removed on 11/23/13. Now that the dorsal stimulator is removed, she is to wait until the initial period of inflammation has subsided before starting her physical therapy in February. Her situation seems to have deteriorated. Her present symptoms have worsened. Her activities of daily living have also suffered significantly. She is not working. Before, she was walking with a cane; now, she is utilizing a walker because she has difficulty standing up. The patient was diagnosed with failed back syndrome, discogenic disease, L5 and S1 radiculopathy, nerve root fibrosis, post dorsal stimulator insertion with removal, and post laminectomy. A pain management re-evaluation on 12/12/13 documented the patient to have a complaint of lower back pain. She indicated that her symptoms are essentially unchanged. For pain, she has been taking Percocet 10/325mg every six hours as needed and Gabapentin 300mg three times a day; she states that the combination of the medications makes the pain tolerable without side effects. She has been compliant with the medication. The risks and side effects associated with the medications were discussed with the patient. She understands them, and states that she needs the medicine to be able to live, function, and have a quality of life. The ibuprofen was stopped, and she was to continue with Percocet 10/325mg every six hours as needed and Gabapentin 300mg three times a day. A PR-2 dated 11/19/13 documented no change since the last examination. A pain management re-evaluation dated 10/22/13 states that the patient reports her symptoms are still the same. She also complains of urinary dysfunction. For pain, she has been taking Percocet 10/325mg every six hours as needed and Gabapentin 300mg three times a day. She has been compliant with the medicine and reports good relief without side effects. She will continue with her Percocet 10/325mg every six hours as needed and Gabapentin 300 mg three times a day, and start on ibuprofen 600mg twice a day.

## IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**PRILOSEC 20MG (NO QUANTITY):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** The California MTUS guidelines state that medications such as Prilosec may be indicated for patients at risk for gastrointestinal events, which should be determined by the clinician. Risk factors include being over 65 years of age; having a history of peptic ulcer, GI bleeding or perforation; concurrently using ASA, corticosteroids, and/or an anticoagulant; or taking high dose/multiple NSAIDs. However, none of the above listed criteria apply to this patient. There are various anecdotes of GI upset and gastritis in the records provided; however, there is no clear subjective and objective evidence that patient has a history of GERD or peptic ulcer disease that warrants a proton pump inhibitor (PPI). The patient had a gastroenterology qualified medical exam on 1/13/14. The physician recommended that the patient significantly increase her water intake and attempt to become more physically active. It does not appear that Prilosec was included in the recommendations. The medical records do not establish that the patient meets the appropriate criteria as to establish she is at risk for gastrointestinal events, to warrant access to the proton pump inhibitor. The guidelines also not that long-term PPI use (over 1 year) has been shown to increase the risk of hip fracture. The medical records do not support the use of Prilosec. As such, the request is not medically necessary.

**PERCOCET 10/325MG:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80, 88.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, continued opioid treatment requires documented pain and functional improvement. A positive response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There is documentation in the records that the patient is experiencing pain that interferes with her daily activities and sleep. The records continue by stating that the combination of Gabapentin and Percocet makes pain tolerable without side effects, and that she has been compliant with the medications. A urine drug screen from October 2013 was positive for the medications that the patient was prescribed, and negative for illicit drugs. Since Percocet is improving the patient's pain level and quality of life, the medical necessity of Percocet has been established.

**GABAPENTIN 600MG:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16.

**Decision rationale:** According to the California MTUS guidelines, anti-epilepsy drugs are recommended for neuropathic pain. The guidelines document that Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered a first-line treatment for neuropathic pain. There is documentation in the records provided that the patient is experiencing pain that interferes with her daily activities and sleep. The records continue by stating that the combination of Gabapentin and Percocet makes her pain

tolerable without side effects, and that she has been compliant with the medications. Since the patient has a history of lumbar radiculopathy and is status post spinal surgery, Gabapentin would be indicated. As such, the request is medically necessary.

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